Struggling with documentation?

How to document a peer’s progress and your work

June 8, 2018
Remember, you are documenting the story of a person’s recovery!
Medical / Health Record Documentation:

• **Official evidence** of the supportive services you’ve provided
• **Legal** proof
• **Record** of service delivery
• Primary **communication** between providers
• Fosters **quality** service delivery
• Supports **continuity of care**
• **Reduces** risks and errors
• Records benefits vs risks of treatment/care
• **Tool** for engagement
Documentation must be:

• Written in a professional and timely manner
• Concise, clear, and accurate
• Written as if the document will be published on the front page of a newspaper
• Written and signed by the person providing the services
Let’s talk about Individualized Recovery Planning
Supporting individuals in articulating personal goals for recovery and wellness; together, creating a plan for achievement.
Individual Recovery/Resiliency Plan

• Record of agreed upon preferences, outcomes, objectives, and interventions

• Record of planned approaches and interventions
  How will we do it?

• Contract of responsibilities
  Who’s going to do what and when?

• Planned changes along the way to the destination
  When do we update or change?
• A “living and breathing” document
  • Changes as situations and desires change / updated regularly
• Guides our actions and direction
• Done with not to or for
• Signed by individual served / provider
Individualized Recovery Planning

Goal
“I intend to …”

Objective #1
(sub goals)

Intervention
(needed action)

Objective #2
(takes more than 1)

Intervention
(more action)

Intervention
(as many as needed)
Individual Recovery Plan (IRP)

Most people don’t walk in with goals; help them discover or uncover theirs!

Goals-

- Specific outcomes
- Clear and simple
- Expressing desire/wishes of individual
- Be in the individual’s words (understandable)
- Change as needed / desired

It’s not about getting a required document into the record; it’s about helping someone discover where they want to go; what they want to be or do and creating a real action plan to get them there!
Individual Recovery Plan (IRP)
Planning is Important!

What we need to reach our dreams:
- Goals & Dreams
  - Well-designed,
  - Organized,
  - Prioritized,
  - Multi-step,
  - S.M.A.R.T.,
  - Flexible,
  - Individualized,
  - Individual-driven,
  - Coordinated,
  - Plan that gets the person where they want to go

What many get:
- Duplicated,
- Non-specific,
- Disorganized,
- Non-prioritized,
- Inflexible,
- Uncoordinated,
- Single-step plans that go nowhere.

Attend & participate
Individual Recovery Plan (IRP)

Your plan

Reality
Challenge Type(s): **Functional: Social**

Challenge Statement:

- “I don’t have many friends so I tend to stay home, focus on my problems, and get more depressed.”

Goal: “I intend to socialize and workout at the YMCA through the end of this year.”
IR/RP Objectives

- Identify necessary steps or “moves”
- Prioritize steps
- Everyday language (keep it real)
- S.M.A.R.R.T.
- **Objective #1:** *John will enroll at the YMCA by July 5, ‘18*
  - CPS will help John enroll by coaching him through the process of making application, paying fees, etc.

- **Objective #2:** *John will use public transportation to the YMCA after July 6, 2018*
  - CPS will assist John with planning his route to the Y and accompany him on his first two trips.
  - CPS will assist John with budgeting for and obtaining a monthly transportation card

- **Objective #3:** *John will exercise at the YMCA at least three days per week for at least 45 minutes each visit.*
IR/RP Interventions

- **Actions** necessary to achieve the objectives
  - Consistent with achieving objectives
  - Can be done by anyone involved
  - Consistent with skill/competence/credential

- **Examples may include:**
  - Teaching skills (not skill categories)
  - Linking to supports (specific)
  - Negotiating for or with individual
  - “Brainstorming” options
  - Increasing Awareness (personal/environment)
Progress Notes:
Documenting your work and their progress
Progress Note Formats*

- **SOAP**
  - Subjective data
  - Objective data
  - Assessment
  - Plan

- **DAP**
  - Data
  - Assessment
  - Plan

- **BIRP**
  - Behavior
  - Intervention
  - Response
  - Plan

- **PIRP**
  - Presentation
  - Intervention
  - Response
  - Plan
Quantitative Items (the basics):

1. DATE of contact / service
2. Correct CODE
3. TIME and UNITS
4. LOCATION of service
5. CONTENT of Note*
6. Your NAME and CREDENTIAL
7. DATE you wrote and signed the note
8. Your SIGNATURE
ABC’s of Writing Progress Notes

Qualitative (Content of the Note*)

1. Goal or objective being addressed (Why you are there; purpose of intervention?)
2. Interventions you provided (what you did relevant to plan)
3. Any additional issues / needs / changes? (what’s new?)
4. Response to intervention (How did it go?)
5. Progress made (Toward the goals / objectives)?
6. What’s your plan for the next time?
Name:  John Doe  
Service Provided:  (H0038U5U7)  
Service Date:  6/2/18  Time In/Out:  9:15 am - 9:48 am  (2 Units)  
Location:  Duck Pond @ Piedmont Park  

B: This is where we describe what we observe and what the individual tells us.  

I: This is where we describe why we’re there and what we did to be helpful. Did I use particular skills or approaches with the peer? What do they? Be specific enough to justify the time you billed and make sure it matches with the definition of the service you’re billing.  

R: This is where I describe the peer’s reaction or response to my help. If I taught a skill, how did it go? Did they get it? Part of it? Did I discover they’re a visual or an experiential learner? Did they make some significant comment about what we did?  

P: This is where I talk about their progress toward their goals or objectives and future steps and actions with the peer. When are we meeting next, where, and why.  

Ima Peerperson / CPS-P  
6/3/18  
Date of Signature
Common Errors in Progress Notes

- “Wordy” notes that document a conversation but miss the interventions, response, and progress
- Documenting diversionary activities
- Activities outside our scope of practice / credential
- Doing for instead of doing with
- Documenting personal opinions or judgements
Non-Billable Activities

• Accompanying
• Transportation
• Generally:
  • Playing games
  • Playing sports
  • Watching movies
  • Surfing the web
• If person is not present . . .
• If person is asleep . . .
• Most anything that’s not directly related to goal attainment
• Job training
• Where intervention isn’t focused on individual served
Example Note: (Vague)

Name:  John Doe  Peer Support Individual (H0038U5U6)
Service Date:  6/2/17  Time In/Out:  9:15 am  -  9:45 am  (2 Units)

B: John was dressed appropriately for the weather when I arrived. I stopped by to see how he’s doing and he feeling good and in a positive mood. He reports using good coping skills.

I: Met with John at the office and he told me he is doing much better and he is going to Peer Supports Group every day. He had a great week and really enjoyed this past weekend. He said he had pizza after a movie last night. Reminded John of importance of using good coping skills. I encouraged him to keep up the good work and I will be back next week to check in on him.
Name: John Doe Peer Support Individual (H0038U5U6)
Service Date: 6/2/17 Time In/Out: 9:15 am - 9:45 am (2 Units)

R: John responded appropriately and was receptive to the information discussed during the session. He stated, “I like your visits and hope I can always have you as my CPS.”

P: The CPS will continue visit the peer later to assist with meeting his goals and objectives and continue helping him work on using his coping skills to help with his depression.

Name: Ima Peerperson, CPS-P Date Entry: 6/2/17
Name: John Doe        Peer Support Individual (H0038U5U6)
Service Date: 6/2/17  Time In/Out: 9:15 am - 9:45 am  (2 Units)

B: John stopped by the office today, very excited about his attending
the neighborhood barbecue on Memorial Day, that he had met many
of his neighbors for the first time, and has hope that he has made a
new friend in the process. He thinks having the new clothes he picked
out last week and working out at the Y is making him feel more
confident in meeting people.

I: CPS congratulated John on his reported progress toward his goal
of making a new friend by getting out into his community, meeting
people, and using his skills of “Introducing himself” and “Starting a
Conversation.” Likewise, he is going to the Y weekly as planned.
CPS congratulated John for actively addressing his emotional barrier
of the fear of rejection.
Name: **John Doe**  Peer Support Individual (H0038U5U6)
Service Date: **6/2/17**  Time In/Out: **9:15 am - 9:45 am** (2 Units)

**R:** John accepted my feedback and encouragement by stating that he realizes it isn’t going to be easy but that stretching himself and taking risks will help him “come out of his shell” and become an active part of his neighborhood.

**P:** John is making significant progress toward his goals as he is using the skills of “Introducing yourself” and “Starting a conversation” with strangers. John is also going to the Y as planned. I will continue to encourage and monitor his progress. We will likely need to meet within the next four weeks to consider any next steps or adjustments to his current plan.

Name: **Ima Peerperson, CPS-P**  Date Entry: **6/2/17**
Questions and Feedback

• What questions do you have?
• What did you learn today?
• What needs further clarification?
• What was your “Aha!” moment today?
Thank you

For Georgia Collaborative ASO general inquiry or questions please email: GACollaborative@beaconhealthoptions.com

Presenters:
Jean Olshefsky, CPS, CARES
John T. Dixon, CPRP
Jerald Carter